**Kidango Behavioral Health Referral Form**

***Important Reminders:***

***\*To help us maintain confidentiality per HIPAA, referral must be faxed, or delivered in a sealed envelope via inner-office mail (Kidango internal) or mailed to:***

# Kidango Behavioral Health Dept.

***44000 Old Warm Springs Blvd., Fremont, CA 94538***

***\*Alameda County Fax#: 510-440-1200/ Santa Clara County Fax#: 408-293-1000***

***Referrals can be sent via secure email to gina.meredith@kidango.org***

***Referral Information:***

Referral Date: / / Phone:

Referred by: E-mail:

Agency/Location:

\*Client Preferred Language: \*Parent Preferred Language:

***Client Information:***

Last Name: Medi-Cal #:

First Name: (must be 8 digits long and starts with a "9")

Middle: If no Medi-Cal, indicate insurance information below: Birthdate: / / M F

***Parent/Guardian Information:***

Parent/Guardian #1: Phone#:

Address:

Parent/Guardian #2: Phone#:

Address:

***Child Currently Resides With:***

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 Biological Parents | 🞏 Biological Parents Separated (Shared Custody) | 🞏 Biological Parent (single parent is primary caregiver) | 🞏 Foster Parent |
| 🞏 Legal Guardian | 🞏 Adoptive Parent | 🞏 Other: |

***Concerns:***

**Please Mark All Concerns that Apply:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hitting/Aggressive Behavior |  | Fighting |  | Speech Concerns |  |
| Defiant Behaviors |  | Social Interaction Concerns |  | Learning Concerns |  |
| Disruptive |  | Difficulty Sharing |  | Motor Concerns |  |
| Destroys Things |  | Screaming/Excessive Crying |  | Other Concerns:  |  |
| Tantrums |  | Trauma (experience/exposure) |  |

*\* To avoid delays, please fill out form completely. Use one form per child.*

*To inquire on status, call our intake specialists:* ***Alameda County,*** ***510-585-9815 or Santa Clara County, 408-200-2912***